Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Division of Alcohol and Substance Abuse,
Juvenile Rehabilitation Administration, and
Medical Assistance Administration

Chemical Dependency

TITLE XIX CONTRACTORS
(WAC 388-805)
Outpatient Billing Instructions

July 2001

About this publication

This publication supersedes all previous Chemical Dependency Billing Instructions.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
July 2001

Received too many billing instructions?
Too few?
Address Incorrect?

Please detach, fill out and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9245
Olympia WA 98507-9245

Magnetic Tapes/Floppy Disks:
Medical Assistance Administration
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I request billing instructions?

Check out our website:
http://maa.dshs.wa.gov

Write/call:

Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Who do I call if I have questions regarding…

Policy or reimbursement rates?

Division of Alcohol & Substance Abuse
PO Box 45330
Olympia, WA 98504-5330
(360) 438-8209

-or-

Juvenile Rehabilitation Administration
PO Box 45720
Olympia, WA 98504-5720
(360) 902-8105

Payments, denials, general questions regarding claims processing, Healthy Options?

Provider Relations Unit
1-800-562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic Billing?

(360) 725-1267
or write to:
Electronic Billing
PO Box 45512
Olympia, WA 98504-5512

Definitions

This section contains definitions and acronyms used in these billing instructions.

Alcohol Abuse - Use of alcohol in amounts hazardous to individual health or safety.

Alcoholism - A disease characterized by:

- A dependence on alcoholic beverages or the consumption of alcoholic beverages;
- Loss of control over the amount and circumstances of use;
- Symptoms of tolerance;
- Physiological or psychological withdrawal, or both, if use is reduced or discontinued; and
- Impairment of health or disruption of social or economic functioning.

Alcoholism and/or Alcohol Abuse Treatment (Outpatient) - Medical and rehabilitative social services provided to an eligible client designed to mitigate or reverse the untoward effects of alcoholism or alcohol abuse and to reduce or eliminate alcoholism or alcohol abuse behaviors and restore normal social, physical, and psychological functioning. Alcoholism or alcohol abuse treatment is characterized by a combination of alcohol education sessions, individual therapy, group therapy, and related activities provided to detoxified alcoholics and their families.

Approved Treatment Facility -A treatment facility, either public or private, for profit or nonprofit, approved by DSHS pursuant to WAC 388-805 and RCW 70.96A.

Assessment - The set of activities conducted on behalf of a new client, for the purpose of determining eligibility, evaluating treatment needs, and making necessary referrals and completing forms. The assessment includes all practices listed in applicable sections of WAC 388-805 or its successor.

For the purpose of determining eligibility for Chemical Dependency Disposition Alternative (CDDA), the set of activities will include completion of:

- The Adolescent Drug Abuse Diagnosis (ADAD);
- The "Kiddie" version of the Schedule of Affective Disorders and Schizophrenia (K-SADS);
- American Society of Addiction medicine (ASAM) and WAC questionnaire forms.

Chemical Dependency - An alcohol or drug addiction, or dependence on alcohol and one or more other psychoactive chemicals.

Chemical Dependency Disposition Alternative (CDDA) – A sentencing option of chemically dependent youth offenders which allows judges to order community-based treatment in lieu of confinement. [RCW 13.40.165]

Client - An applicant for, or recipient of, DSHS medical care programs.

Division of Alcohol and Substance Abuse (DASA) – A division within DSHS responsible for providing alcohol and drug related services to help clients recover from alcoholism and drug addiction.

Department - The state Department of Social and Health Services.
[WAC 388-500-0005]

Drug Abuse - The use of a drug in amounts hazardous to a person's health or safety.

Drug Addiction - A disease characterized by:

- A dependency on psychoactive chemicals;
- Loss of control over the amount and circumstances of use;
- Symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued; and
- Impairment of health or disruption of social or economic functioning.

Drug Addiction and/or Drug Abuse Treatment - Medical and rehabilitative social services provided to an eligible client designed to mitigate or reverse the effects of drug addiction or drug abuse and to reduce or eliminate drug addiction or drug abuse behaviors and restore normal physical and psychological functioning. Drug addiction or drug abuse treatment is characterized by a combination of drug and alcohol education sessions, individual therapy, group therapy and related activities provided to detoxified addicts and their families.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – (Formerly referred to as the "Healthy Kids" program.) A program providing early and periodic screening, diagnosis and treatment to persons under twenty-one years of age who are eligible for Medicaid or the children's health program.

Expanded Chemical Dependency Assessment for Division of Children and Family Services (DCFS) - Comprehensive assessments of adults who are referred by DCFS staff that include: chemical dependency diagnosis, the assessment tools used, treatment recommendations and prognosis, urinalysis, psychosocial history, and family and collateral contacts.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Group Therapy - Planned therapeutic or counseling activity conducted by one or more licensed therapists to a group of three or more unrelated individuals and lasting at least 45 minutes. Acupuncture may be included as a group therapy activity.

Health Maintenance Organization (HMO) – An entity licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the department on a prepaid capitation risk basis.
[WAC 388-500-0005]

Healthy Options – See Managed Care.

Individual Therapy - A planned therapeutic or counseling activity provided to an eligible client by a licensed therapist or group of therapists. Individual therapy includes treatment provided to a family group consisting of a primary client and one or more significant others, or treatment provided to a couple who are married, contemplating marriage, or living together.

Initial Screen – Component of the DCFS expanded assessment process in which the chemical dependency agency:

- Begins the assessment process;
- Completes the initial-short assessment and the urinalysis; and
- The client fails to return to complete the full assessment.

Intake Processing- The set of activities conducted on behalf of a new client. Intake processing includes all practices listed in applicable sections of WAC 388-805 or its successor. Intake processing includes obtaining a written recommendation for chemical dependency treatment services from a referring licensed health care practitioner.

Juvenile Rehabilitation Administration (JRA)- An administration within DSHS responsible for providing a continuum of preventative, rehabilitation, residential, and supervisory programs for juvenile offenders and their families.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Maximum Allowable - The maximum dollar amount for which a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320.

[WAC 388-500-0005]

Medical Assistance Administration (MAA) - The administration within the Department of Social and Health Services authorized to administer the acute care portion of the Title XIX Medicaid and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Opiate Substitution Treatment - Services provided to clients in accordance with WAC 388-805-730 or its successor. Services are consistent with all state and federal requirements and good treatment practices and must include, as a minimum, the following services: physical examination upon admission; urinalysis testing one time per month; initial treatment plan and treatment plan review one time per month; vocational rehabilitation services as needed (may be by referral); dose preparation and dose dispensing; detoxification if and when needed; patient case management; individual and/or group counseling one time per month; one session of family planning; HIV screening, counseling, and testing referral; and psychological screening.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

a) First and middle initials (or a dash [-] must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tiebreaker).

Physical Examination – For the purpose of the Chemical Dependency program, means an examination on a patient who was dependent on barbiturates or benzodiazepines, or who used intravenous drugs within 30 days of admission to treatment. The examination must be conducted by a physician or other health care practitioner within their scope of practice under state law. The examination is provided to:

- Determine if the person is physically stable to be able to participate in treatment; or
- Check for other diseases and medical complications in the case of the IV needle user.

Pregnant and Postpartum Women (PPW) Assessment – Assessment provided to an eligible woman who is pregnant or postpartum. The postpartum period covers the 60 days after delivery and any remainder of the month in which the 60th day falls.

Program Support, Division of (DPS) - The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Remittance and Status Report (RA) - A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Temporary Assistance For Needy Families (TANF) - The federal welfare program established in 1996 that combined the Aid to Families with Dependent Children (AFDC) (cash aid) and the JOBS Opportunities and Basic Skills (welfare-to-work) programs into one program funded by one federal block grant.

TANF Client - Clients eligible for TANF who are receiving assessment and treatment services.

Third Party - Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. [42 CFR 433.136]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Tuberculosis (TB) Testing - Administration and reading of the Intradermal Skin Test, to screen for tuberculosis, by: licensed practitioners within the scope of their practice as defined by state law or by DOH WACs; or as provided by a tuberculosis community health worker approved by the DOH

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed 1) the usual and customary charge that you bill the general public for the same services, or 2) if the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) Codified rules of the State of Washington.

Youth - Individuals over 9 and under 21 years of age.

Chemical Dependency

Who should use these billing instructions?

These billing instructions should be used by **outpatient chemical dependency treatment centers** contracted through the Division of Alcohol and Substance Abuse (DASA) and Juvenile Rehabilitation Administration (JRA).

DASA is responsible for establishing an alcoholism and drug abuse prevention program and for providing a continuum of alcoholism and drug abuse treatment services to help persons recover from alcoholism and drug addiction. DASA does this by assuring quality of treatment services in the state, contracting with counties and private organizations to provide treatment, and establishing prevention programs.

Use these billing instructions and fees in conjunction with your contract on file with the Department of Social and Health Services, Division of Alcohol and Substance Abuse. ***Contract stipulations always take precedence over billing instructions.***

Client Eligibility

Who is eligible?

Only clients presenting Medical Assistance IDentification (MAID) cards with the following identifiers **are eligible** for services under the Chemical Dependency Program:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP Children's Health	Children's Health Program
CNP – CHIP	Children's Health Insurance Program
LCP-MNP	Limited Casualty Program - Medically Needy Program

The client's MAID card must show eligibility for the date(s) services are rendered.

Examples of who is not eligible

Clients who present a MAID card with one of the following identifiers are **not eligible** for treatment services under the Chemical Dependency Program. **These are only examples and should not be considered an exhaustive list.**

Medical Program Identifier	Medical Program Name
CNP – Emergency Medical Only	Categorically Needy Program – Emergency Only
Detox Only	DETOX
Family Planning Only	Family Planning
GA-U No Out of State Care	General Assistance - Unemployable
MIP – EMER Hospital Only No out-of-state care	Medically Indigent Program
QMB Medicare Only	Qualified Medicare Beneficiary – Medicare Only
TAKE CHARGE	TAKE CHARGE Family Planning Program

Are clients who are enrolled in a managed care plan eligible for services under the Chemical Dependency program?

Yes! Clients who are enrolled in a managed care plan are eligible for Chemical Dependency services outside their plan. MAA reimburses chemical dependency services through fee-for-service. **No referral is required from the managed care plan when services are provided by DASA providers.**

Clients who are enrolled in a managed care plan will have an "HMO" identifier in the HMO column on their MAID cards.

Coverage/Limitations

SERVICE	LIMITATION
Chemical Dependency Assessment	• Covered for new and returning clients only if the date of intake occurs more than 30 days from the last date of any covered outpatient treatment services by the same agency.
Initial Screen	• Covered once per client. • Do not bill until 60 days after the screen was completed and the sample collected.
Expanded Chemical Dependency Assessment	• Covered for new and returning clients only if the date of intake occurs more than 30 days from the last date of any covered outpatient treatment services by the same agency. • If an Initial Screen has been billed for a Division of Children & Family Services (DCFS) referred client, the billing for the expanded assessment must be reduced by the amount of the initial screen, as the Initial Screen is a component of the expanded assessment for a DCFS client.
Intake Processing	• Covered for new and returning clients only if the date of intake occurs more than 30 days from the last date of any covered outpatient treatment services, except for an assessment, by the same agency.
Physical Examination	• Covered only for eligible clients who are dependent on barbiturates or benzodiazepines, or who used intravenous drugs within 30 days of admission. • Covered at the time the client initially enters treatment – once per admission. • Not covered for clients receiving daily opiate substitution treatment services, as it is included in the payment rate for that service. • Not covered when provision of this medical service is available through the client's primary care provider.
Individual Therapy – Full Visit	• Covered once per day, per client. • A session more than 45 minutes in duration constitutes a full visit.
Individual Therapy – Brief Visit	• Covered once per day, per client. • A session of 15 minutes to 45 minutes in duration constitutes a brief visit.

SERVICE	LIMITATION
Group Therapy	• Covered up to 3 hours per day. • Claims for group therapy may be made only for those eligible clients or their families within the group. • One unit equals 15 minutes. • Group therapy is covered only when provided for a minimum of 45 minutes (3 units) up to a maximum of 3 hours (12 units) per client, per day. • Acupuncture is considered a group therapy procedure for the primary client. **Note:** When family members attend a group therapy session either in lieu of, or along with, the primary client, the session may be claimed only once regardless of the number of family members present.
Opiate Substitution Treatment	• If provided, covered once per day while a client is in treatment.
Tuberculosis (TB) Testing	• TB testing is a covered service when provided by a licensed practitioner within the scope of his/her practice as defined by state law or by the Department of Health WACs, or as provided by a tuberculosis community health worker approved by the Department of Health.
Urinalysis-Drug Screening	• Urinalysis-drug screenings are covered only for methadone patients and pregnant women. • A urinalysis drug screening must be billed through DASA's contracted provider. **Call DASA at (360) 438-8091 for more information.**

Note: Services provided to children under 10 years of age must be pre-approved by the DASA contract manager.

Alcohol and Drug Treatment Outpatient Service Fee Schedule

For Services Provided on and after July 1, 2002

Procedure Codes						Service	Fee-for-Service Maximum Rates
Non-TANF Adults	TANF Adults	Youth	SSI Clients*	JRA Youth CDDA Locally Sanctioned	JRA Youth CDDA Committable		
2175M	2175M					DCFS Initial Screen	$18.33
2170M	2177M					DCFS Expanded Chemical Dependency Assessment	$177.69
0140M	2140M	0160M	2130M*	2181M	2188M	Chemical Dependency Assessment	$91.22
0150M	0150M					Pregnant & Postpartum Women Assessment	$91.22
0141M	2141M	0161M	2131M*	2182M	2189M	Intake Processing	$13.38
0142M	2142M	0162M	2132M*			Physical Examination	$71.43
0143M	2143M	0163M	2133M*	2183M	2193M	Individual Therapy - Full Visit	$56.85
0144M	2144M	0164M	2134M*	2184M	2194M	Individual Therapy - Brief Visit	$30.35
0149M	2149M	0169M	2135M*	2185M	2195M	Group Therapy	$4.47 per 15 minutes
		0028M*		2186M*	2196M*	Youth Case Management*	$194.35
0190M	2190M	0192M	2139M*			Opiate Substitution Treatment	$10.36
86580	86580	86580	86580	86580	86580	Tuberculosis Testing	$5.92

***The billing of these services and the use of these procedure codes are restricted to those providers who are currently contracted with the counties to provide these services.**

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- Providers must submit initial claims and adjust prior claims in a timely manner. MAA has two timelines standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in the appropriate MAA billing instruction.

- Providers must submit their claim to MAA and have an Internal Control Number (ICN) assigned by MAA within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

1 **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

2 **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- MAA requires providers to bill third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time periods listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

What fee should I bill MAA?

Bill MAA your usual and customary fee.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the *Comments* field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov/ or by calling the Coordination of Benefits Section at 1-800-562-6136.

What must I keep in the client's file?

[WAC 388-503-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for six years from the date of service or longer if required specifically by federal or state law or regulation.

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern DSHS's programs. [WAC 388-502-0020(2)]

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

  If you need preprinted red and white HCFA-1500 claim forms, **call 1-800-562-6188.**

- **Do not use red ink pens, highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field Description/Instructions

1a. **Insured's I.D. NO.**: **Required**. Enter the MAA Patient (client) Identification Code (PIC) alphanumeric code exactly as shown on the client' MAID. The PIC consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker).

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: **Required**. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: **Required**. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, federal health insurance benefits, military and veteran's benefits) list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: **Required**. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. If the client has insurance secondary to the insurance listed in *field 11*, enter it here. When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.

9A. Enter the other insured's policy or group number *and* his/her Social Security Number.
9B. Enter the other insured's date of birth.
9C. Enter the other insured's employer's name or school name.

9D. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc. are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: **Required**. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24.* ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11A. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3.*

11B. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11C. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11D. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a. - d.* If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes.* If **11d** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name. This field *must* be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17A. **I.D. Number of Referring Physician**: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the PCCM referred the service, enter his/her seven-digit identification number here. *If the provider does not have an MAA provider ID number, be certain field 17 is completed.*

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

24. **Enter only ONE (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 form. Total each claim separately.**

24A. **Date(s) of Service**: **Required**. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 04, 2001 = 070401).

Do not use slashes, dashes, or hyphens to separate month, day, year (MMDDYY).

24B. **Place of Service**: **Required**. The following is the only appropriate code(s) for Washington State Medicaid:

Code Number	To Be Used For
3	Office or center

24C. **Type of Service**: **Required**. Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: **Required**. Enter the appropriate procedure code for the services being billed.

24E. **Diagnosis Code**: Enter **303.9** (for alcohol dependency) **or** **304.9** (for drug dependency).

For youth and pregnant & postpartum women, the following diagnosis codes may be used to distinguish abuse: **305.0** (for alcohol abuse) **or** **305.9** (for drug abuse).

A diagnosis code is required on each line billed. For assessment purposes, the diagnosis code does not reflect the outcome of the assessment or the diagnosis of the client.

24F. **$ Charges**: **Required**. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field.

24G. **Days or Units**: **Required**. Enter the total number of days or units for each line. These figures must be whole units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Control Number.*

28. **Total Charge**: **Required**. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or patient paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: **Required**. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: **Required**. Put the name, address, and telephone # on all claim forms.

GRP#: Required. Enter the seven-digit number assigned to you by MAA.

Sample:
HCFA-1500 Claim Form

See Separate File